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ABSTRACT

This booklet is the first in a series providing practical information about major issues in the promotion of child health. Discussion is grouped into four parts. The first part, on health maintenance, discusses the features and significance of good checkups and addresses the need for parents to discuss menstruation as a normal, healthy part of becoming a woman. Dealing with nutrition, the second part explains the causes, effects, and prevention of iron deficiency anemia. The third part, on mental health, describes hyperactivity, providing a four-question test for evidence of hyperactivity and discussing treatment priorities. Television violence is also discussed, and 10 tips to maximize the benefits of television viewing are included. The fourth part, on the environment, identifies the sources of excess lead in urban areas, describing the signs and effects of lead poisoning and suggesting preventive measures. A brief concluding note stresses the importance of preventive health care for children. (AS)

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YOUR CHILD AND GOOD HEALTH: SIX TOPICS IN URBAN PREVENTIVE CHILD HEALTH

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by Karl E. Hammonds, M.D.

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November 1984

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Karl E. Hammonds, M.D., is a Washington, D.C. based pediatrician, medical journalist, and child health advocate. An active practicing physician, he also lectures frequently at academic institutions, health care facilities, and civic gatherings. His award-winning consumer health radio broadcast, "Focus On Your Health," can be heard on Sunday mornings on WGAY, from Silver Spring, Maryland. Dr. Hammonds has won awards for his writings and community service from Princeton University, the District of Columbia Lung Association, American Cancer Society, American Academy of Pediatrics, and *Writer's Digest.*

Dr. Hammonds states, "This is an information era, especially for parents. All those who care for or about children need to be well-informed about prevention in child care. Only in this manner can we save on health care costs, and insure proper growth and development for each child, both now and in the foreseeable future." *Your Child and Good Health: Six Topics in Urban Preventive Child Health* exemplifies his beliefs.

Dr. Hammonds is also available as a resource person for speaking engagements, seminars, and conferences. For additional copies of this book, write to:

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FOREWORD

Your Child and Good Health: Six Topics in Urban Preventive Child Health is presented as a unique collection of original articles on health maintenance, nutrition, mental health, and environment. These are selected subjects, in response to the particular informational needs of parents and other child care providers in urban areas. Much of the information herein, however, is widely applicable to other populations with similar needs and concerns.

The particular topics targeted are those frequently discussed by Dr. Hammonds in clinical, academic, journalistic, and civic settings. This fresh approach makes the information interesting, available, and affordable to the general public. Once having read further, you will sure agree.

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JOAN

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INTRODUCTION

Virtually all children can benefit from preventive care. This care does not occur exclusively in physicians' offices and clinics. On the contrary, the majority of both well and sick child care occurs in the homes and in other child care settings. The care is delivered by parents, relatives, friends, babysitters, day care workers, teachers, and recreation leaders. These admirable individuals usually have little or no medical background, which is often unnecessary in daily child rearing. The true necessities are common sense, some experience, and good advice.

This book arose from the needs expressed during many conversations, particularly with urban parents and other child care providers. The overwhelming outcry was for practical information to assist in understanding major issues in child health promotion. An easy-to-read, concise, "how-to" booklet was in order. *Your Child and Good Health: Six Topics in Urban Preventive Child Healt* is the first in a series of such booklets. The areas of concern targeted are Health Maintenance, Nutrition, Mental Health, and Environment. One or two specific subjects are addressed under each heading.

HEALTH MAINTENANCE incorporates habits and practices that assure good health. The first article, "Check-ups for Children," answers the basic question: "Why should I take my child to the doctor when he isn't sick?" The features and significance of good check-ups are elaborated. The second article, "For Mothers and Laughters Only," is not truly for mothers and daughters only. It addresses the need to discuss menstruation as a normal, healthy part of becoming a woman. Girls need to receive guidance and understanding ahead of time, and to continually communicate after the fact. The results could otherwise be potentially devastating to the unsuspecting girl, as is the case with Ronnette, a fictitious 11-year-old. Counselling tips are given.

NUTRITION is truly the cornerstone of good health, especially during childhood. "Insights on Iron Deficiency" explains the causes, effects, and preventon of iron deficiency anemia, the most prevalent nutritional deficiency in childhood.

MENTAL HEALTH is as important as physical health. In fact,

the two are very closely linked when one considers the well-being of the total individual. Mental health involves self-image, aspirations, dreams, fantasies, cognitive thinking, emotions, and their subsequent influences on one' actions and beliefs. "Is Your Child Hyperactive?" explains the overused term "hyperactivity," and sets it into perspective with other normal and abnormal occurrences. A simple 4-question test for evidence of hyperactivity syndromes is included, along with treatment priorities. "Television Violence" is a controversial subject often discussed by the author. Television is an all-pervasive medium, viewed by the majority of American children (and adults). It not only informs and entertains, but shapes attitudes, values, and behavior. Ten tips on taming the television set are included.

ENVIRONMENT in urban areas can be quite a problem due to noise, pollution, poverty, and other serious stigmas. "Keeping Ahead of Lead Poisoning" identifies the sources of excess lead in urban areas, the signs and effects of lead poisoning, and preventive measures. Simply stated, lead poisoning is entirely preventable.

The conclusion, "A Personal Note," gives the author's view of prevention and advocacy in the changing world of child care.

Part I:
HEALTH MAINTENANCE

MAIN
STACK

CHECK-UPS FOR CHILDREN

Parents often ask, "Why should I take my child to the doctor office when she is not sick? And why so often?" These parents hav valid concerns about their time, money, and the quality of care fo their children. For the working parent, a visit to the pediatricia may mean a few hours lost from work, or personal relaxation an home life. To the child, there is interruption of the daily establishe routine (day care, school, naps, playtime, etc.).

There are many individual reasons for well-child check-ups, whic can best be categorized in two areas. First, the well-child check-u identifies potential problems that may not be causing any symptom at present. Examples include hernias, tooth decay, flat feet, visio and hearing defects. Secondly, and equally important, is health pr motion. For children, this means monitoring and insuring prope growth and development. This process will involve measuring heigh weight and head size, physical examinations, developmental test immunizations, and laboratory tests. The well-child visit gives th parents, children, and pediatrician the chance to become comfortabl with one another. It is also a prime opportunity for questions to b answered, and for *anticipatory guidance*.

SPECIAL QUESTIONS

Questions range from those involving physical problems to man concerning feeding practices, home remedies, behavior, or scho performance. Parents should feel comfortable asking their pediatr cian *any* questions about their children and families. These ma include sensitive areas, such as racism, sex education, child abus divorce, or death in the family. Older children and teenagers shoul when necessary, be able to speak with the pediatrician without th parents present. This may occur in the office or by telephone. Th pediatrician, in turn, should be knowledgeable, personable, and no judgemental in his or her approach to answering questions. Picture brochures, and pamphlets are usually quite helpful for answerin

questions and stimulating home discussion of sensitive areas. The family and doctors should readily admit that, at times, there is no one answer or approach to a problem or question. Careful referrals and references can then be made.

ANTICIPATORY GUIDANCE

Anticipatory guidance is the cornerstone of pediatrics and child health. This term means "good advice" about what can be expected from children in the near future. For example, the average 6-month-old can be expected to walk by age 12 months. Two-year-olds, characteristically, become stubborn, selfish, and jealous for affection. Children entering school or day care can be expected to have more colds and minor infections than children remaining at home. Through discussions and literature, the pediatrician can assist parents in preventing upcoming trouble areas. Anticipatory guidance concerning accident prevention is essential. One-third of all young children will be involved in serious accidents this year. Most of these accidents will occur in or near home. Therefore, most accidents are preventable. These include falls, burns, poisonings, playground and automobile accidents. Safety is a major concern to all who work with children.

FROM BIRTH ONWARD...

Well-child check-ups actually begin before birth, during the mother's pregnancy. The mother's health, the baby's size and heart rate are all monitored during prenatal visits. At birth, the infant is examined immediately, and tested for blood disorders. The first well-baby visit in the doctor's office should occur at two (2) weeks of age. Subsequent well check-ups should be at these ages:

- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 2 years
- Every year until adulthood

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WHAT TO EXPECT AT CHECK-UP TIME

A typical well-child check-up should include the following seven (7) steps:

1. Discussion of any health or psychosocial problems;
2. Measurement of physical growth: height, weight, and head size;
3. Monitoring of development: ages at which the child rolls over, sits up, crawls, speaks, walks, etc.;
4. Physical examination to detect gross or subtle abnormalities;
5. Laboratory tests: blood and urine tests; hearing and vision screening; PAP test in teenage girls;
6. Immunizations to protect against diseases such as polio, tetanus, measles, mumps, diphtheria, and whooping cough;
7. Anticipatory guidance concerning the child's future development and prevention of problems.

WHEN TO CALL THE DOCTOR

Even the best well-child check-ups cannot prevent *all* childhood illnesses or accidents. Therefore, at times, it is necessary to call your child's doctor for advice. Use the following as guidelines:

- A dramatic change in bowel habits, bladder, habits, sleep, or play patterns.
- Any accidents, especially, burns, near-drownings, falls, eye injury, or head injury.
- Fever in excess of 102 degrees, or any fever uncontrolled for 8 to 12 hours.
- Abnormal vomiting, bleeding, or complaints of pain.
- Cold and allergy flare-ups.
- Skin rashes or infections.
- Possible exposure to infection, such as measles, strep throat, or tuberculosis.
- Any time your child is treated in an emergency room.
- Whenever you are in doubt about calling, *go ahead and call.* You and your doctor will both benefit.

Maintaining good health is not easy. However, with consistency, good communication, and follow-up, your child can grow up healthy and happy.

FOR MOTHERS AND DAUGHTERS ONLY

Ronnette awoke early, at the break of day. Somehow, this morning she felt unusual, different, uncomfortable. During the entire week she had experienced pains in her lower left side, occasional headaches, and nausea. She told her mother about it twice. Her mother hurriedly responded, "You will be all right. You must be playing too hard after school." Ronnette's mother always seemed too busy to talk to her, other than to scold her when she did something wrong. There were always telephone calls, or television shows, or other work that took her mother's time and concerns. Also, there was Reggie, her 7-year-old-brother, who seemed too mischievous and energetic for his own good. He always competed for mother's time, and usually won. Ronnette began feeling isolated and rejected. As she arose from the bed, she saw something. There was blood on her sheet and on her pajamas. Her mind raced, "Am I sick? Am I dying?" She stood still in awe, a quiet panic. She remembered her friend Sandy's conversation at school, from a few days earlier. Sandy spoke of her 15-year-old cousin who had "periods," and she was going to have a baby. All of the grown-ups were angry at her cousin. Ronnette wondered, "Am I going to have a baby now?" Fear and confusion accelerated as her slender fingers desperately pulled at the fitted sheet, trying to remove it from the bed. Perhaps, she could hide the evidence. She felt that she had to hide it! Suddenly, her mother appeared at the opened bedroom door, and exclaimed, "Ronnette, what in the world are you doing?" Ronnette felt her heart sink, as the warm tears began to stream slowly down her cheeks.

Confusion, Fear, and Poor Communication

Ronnette is a fictitious 11-year-old girl, who is not unlike many other young girls experiencing their first menstrual period (Menarche). Her problem is not so much the menstrual period, as how to handle the changes associated with it. Her anxiety arises from lack of knowledge and understanding, and poor communication with older

women, especially her mother. Her confusion and fear are aggravated by the misunderstanding of Sandy's cousin's pregnancy, and of the relationship between menstrual periods and pregnancy.

As a Girl Grows Up

Adolescence is a complex, and sometimes difficult, time for young people and their parents. It is a time of rapid physical, mental, and psychosocial development. It is a time of transition from childhood to adulthood. Probably the most difficult situations arise because of emerging sexual maturity. This is especially true for girls.

Menarche (the first menstrual period) generally occurs between the ages of 12 and 13 years. It may occur as early as age 9, or as late as age 16, and still be considered normal. The wide age variability is due to genetic, nutritional, and environmental factors, such as the age of menarche in other female family members, presence of chronic illnesses, and diet. Prior to the onset of menses (sometimes, even several months), girls may experience a variety of uncomfortable events. These include:

- Abdominal pains
- Breast tenderness and congestion
- Nausea
- Swelling of hands, feet, or abdomen
- Slight vaginal discharge
- Increase in body odor
- Body hair in armpits and groin
- Acne
- Headaches
- Mood changes

These unpleasant occurrences are due primarily to changes in the body's sex hormone levels. Very few, or all of these, may occur in the same girl. Conversely, some girls experience menarche with "no warning at all." One should also remember that the above-mentioned changes could be early signs of disease or other disorders. Therefore, these signs should be considered seriously, though calmly. A visit to the family doctor, pediatrician, or gynecologist may be necessary to rule out any abnormalities, and to reassure the family that all is well. The health care provider should be skilled, sensitive, patient, and *experienced* in dealing with adolescent changes and concerns.

The Menstrual Cycle

Menstruation is a natural, healthy part of being a woman. It should not be viewed as a curse, disease, or burden. It is simply a sign of one's physical readiness to have children. When an *egg cell* is released from one of the ovaries, it travels through a *fallopian tube* into the *uterus*. If the egg is *fertilized* a new life will begin. This new life will need nourishment, so the lining of the uterus thickens. This lining is mostly blood vessels, and stored protein and sugar. If the egg is not fertilized, the lining is no longer needed. Both the egg and the lining crumble, forming the *menstrual flow*. The menstrual fluid flows out of the uterus, through the *vagina*, and out of the body. The flow may last from 2 to 7 days. Regular menstrual periods usually occur every month. Everybody is different, and therefore every woman should learn her own individual pattern.

How Can I Help Her?

Here are some tips to help mothers (and others) explain menstruation to their girls:

1. Begin early! Don't wait until it happens! Age 9 or 10 is not too early.
2. Explain the female reproductive system in simple terms. Proper names such as *uterus, ovary, fallopian tubes*, and *vagina* should be used. Diagrams are helpful.
3. Emphasize menstruation as a natural, healthy part of being a woman.
4. Keep a calendar. Have your girl mark the days of menstruation. Review the calendar together every 3 to 4 months.
5. Establish good hygiene and grooming habits (i.e., care of skin, hair, nails, clothing, make-up, diet, tampons, etc.).
6. Be a good role-model as a mother/guardian, relative, or friend. Encourage comraderie among girl friends.
7. Keep the lines of communication open. Questions and problems *always* arise.

Helpful books, pamphlets, and advice can easily be obtained from your doctor, the library, or planned parenthood office. A telephone call or a brief visit may be all that is needed. The time and energy will be well and wisely spent.

With appropriate care, concern, and communication, all girls can grow up and enjoy entering womanhood.

Part II:
NUTRITION

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INSIGHT ON IRON DEFICIENCY

I am pleased as a pediatrician to hear more parents asking questions about iron for their children. "What is iron?" "Where does it come from?" "Why is iron so important?" "Is my child getting enough iron?" These, and other questions, indicate the high level of concern about iron and iron deficiency anemia in children. Parents' questions are certainly in order because iron deficiency anemia is the most common nutritional deficiency in children. It is widespread in pediatric populations in the United States and around the world. Surveys done in the United States have revealed that up to one-fourth of infants between 6 and 24 months of age have iron deficiency anemia. Nearly two-thirds of infants in certain areas are iron deficient without being anemic (low blood count). These alarming occurrences are most common among the poor.

WHY IS IRON SO IMPORTANT?

Iron is necessary to make *hemoglobin* in red blood cells. Hemoglobin is the red substance in blood that carries life-giving oxygen to all parts of the body. Much iron is also stored in the bone marrow, or used in certain bodily chemical reactions. A lack of iron, therefore, can affect nearly every system in a child's body. The following are some of the various effects of iron deficiency:

- Anemia
- Growth retardation
- Poor school performance
- Short attention span
- Decreased short-term memory
- Faulty digestion
- Loss of appetite
- Loss of energy
- Fussiness, irritability
- Increase in infections

The best sources of iron include breast milk, prepared infant formulas

meats, eggs, dried beans and peas, cereals, wheat, dark leafy green vegetables, dried fruits, and peanut butter. Cow's milk contains very little iron, and refined sugar has none. (See table 1).

TABLE I

IRON RICH FOODS ARE GOOD BODY BUILDERS

APRICOTS	PEACHES
BEANS	PEANUT BUTTER
BREAST MILK	PEAS
CEREAL (IRON FORTIFIED)	PRUNES
CHARD	PRUNE JUICE
CHICKEN	RAISINS
DATES	SPINACH
EGGS	STRAWBERRIES
FISH	TOMATOES
GRAPES	TOMATO JUICE
GREENS	TURKEY
INFANT FORMULA (WITH IRON)	WHEAT GERM
MOLASSES	WHOLE WHEAT BREAD

HOW IRON DEFICIENCY OCCURS

With these varied sources available, how does iron deficiency occur? All newborns have certain stores of iron, obtained from their mothers during pregnancy. Premature infants have less iron. These iron stores can last up to 3 or 4 months. If additional iron is not provided in the diet, then the young infant will be well on the way toward iron deficiency before 6 months of age. Also, the average baby will triple his birth weight in the first year of life. This period of rapid growth and development requires additional iron. Many parents introduce cow's milk to their children before one year of age. Cow's milk is a poor source of iron, and may even cause intestinal bleeding in infants. Therefore, most prediatricians recommend that babies not be put on whole cow milk until 1 year of age.

Preschool children between 3 and 4 years of age are at risk, too. At this age, many youngsters become very "picky" eaters, shying away from meats or healthy vegetables. They may prefer juices, starches, or sweets which are poor iron sources. Therefore, we find in many inner-city areas that nearly half of the preschool children suffer from iron deficiency anemia. Adolescents are prone to iron

deficiency, due to rapid growth and hormone changes, coupled with poor eating habits (junk foods, eating-on-the-run, etc.). Adolescent girls, in particular, are at greater risk. From 11 to 27 percent of them may be iron deficient or anemic.

Other diseases can aggravate or be aggravated by iron deficiency. These are:

- Other anemias (thalassemia, sickle cell)
- Bacterial infections
- Cancer
- Kidney disease
- Bowel Disorders
- Juvenile rheumatoid arthritis
- Lead poisoning

Deficiencies of vitamin A and vitamin C accompany iron deficiency. In fact, vitamin C aids in the body's utilization of iron. Therefore, some therapeutic iron compounds contain vitamin C (ascorbic acid) to aid in the iron therapy.

WHAT CAN BE DONE?

A few simple suggestions can be very helpful.

1. Good prenatal care and nutrition for all pregnant women.
2. Breast milk or iron-fortified formula for the first year of a child's life.
3. Iron-fortified cereals when solid food is begun in infancy.
4. A variety of attractive, tasty, iron-rich foods for preschool children and adolescents.
5. Regular well-child check-ups, including blood tests to detect anemia and iron deficiency.
6. When necessary, vitamins and iron supplements as recommended by a qualified health professional.

Iron deficiency is a widespread public health problem, with many serious consequences. However, well informed parents and sensitive health professionals can effectively combat and alleviate it. In turn, our children will have the opportunity to grow up happy and healthy.

Part III:
MENTAL HEALTH

IS YOUR CHILD HYPERACTIVE?

Even though hyperactivity has been described in the medical literature since 1884, it is still misunderstood by many parents, teachers, and health professionals. Unfortunately, magazine articles and television programs also have often been overly simplified and misleading. Hyperactivity is a complex medical problem, with no easy or quick solutions. These children need support, understanding, and, most of all, *patience*, day after day. The treatment often takes years.

DESCRIPTION

The hyperactive child has extreme difficulty in paying attention and sitting still, for even short periods of time. Most hyperactive children are boys. These problems are often noticed before 7 years of age, usually between 2 and 4. Most doctors believe that these children have immature or abnormal nervous systems, making them *unable* to behave normally without some assistance. Therefore, hyperactive children become frustrated, resentful, and angry. Teachers and parents, in turn, may label, condemn, or give up on these children.

FOUR SIMPLE QUESTIONS

You may be suspicious that a certain child is hyperactive. If so, ask these four simple questions about him.

1. Is he able to sit through his favorate television show?
2. Does he sit through a meal without getting up?
3. Can he sit still when playing with a favorite toy?
4. Does he sleep through the night?

If you answer 3 or more questions "yes," then the child is not truly hyperactive. If you answer 3 or more questions "no," then the child needs further evaluation by a doctor. The doctor can then check

thoroughly for the three (3) main behavior problems of hyperactivity syndromes.

- Attention problems (not listening, failing to finish work, poor concentration)
- Impulsive behavior (difficulty waiting his turn, acting out, poor organization)
- Hyperactive behavior (running and climbing on things, fidgeting, restless sleeping)

In this manner, true hyperactivity will not be confused with conduct problems, specific learning disabilities, or mental retardation. Also, the severity of the problem can be properly assessed.

TYPES OF HYPERACTIVITY

There are many types of hyperactivity. Some of the major types are as follows:

- Minimal Cerebral Dysfunction may involve clumsiness, hearing or vision defects. It is caused by prematurity, head trauma, and infections like meningitis. Some of these children are retarded.
- Constitutional Hyperactivity. These children are normal, except for increased physical activity, and sometimes restless sleep. They are usually young boys. In their teenage years, they tend to slow down considerably.
- Situational Hyperactivity is characterized by outbursts of physical acvitity triggered by stress (parent arguments, fear of school, etc.)
- Drug-related hyperactivitgy can be caused by asthma medications, cough syrups, seizure medicines, and steroids.
- Certain diseases, like lead poisoning or thyroid disease, can also be causes.

Even some foods (refined sugar) and additives (food coloring, preservatives) are thought to cause or aggravate hyperactivity. There are many children, however, for whom no definite cause can be identified.

TREATMENT: A TEAM APPROACH

Treatment requires a team approach. Parents are the most

important therapists. They should not feel guilty, or give in too easily to their child's whims. Nor should they punish the child too much. One should set realistic goals and praise accomplishments. Rules should be very few, and simple, but *strict*. Schedules should be predictable for the child (playtime, naptime, mealtime, worktime, bedtime). Planned periods of physical activity should be woven into the schedule to release excess energy.

The teacher's approach should be similar to the parent's approach. The teacher should be able to recognize that hyperactivity and conduct problems are not the same, and require different solutions. The hyperactive child may remain in regular class rooms, and just be paced differently. His subjects should be given in shorter time slots, and at times, special classes and special teachers are needed.

The primary role of the doctor is to confirm the diagnosis and cause, if possible. Then, treatment planning and counselling are begun. Drug therapy is reserved for only the most extreme, difficult cases. These drugs act on the nervous system. Therefore, all of these medicines are dangerous if used excessively. Most of these drugs (Ritalin, Dexedrine, Cylert) stimulate the nervous system. Others may be tranquilizers (Mellaril, Thorazine), or anti-depressants (Tofranil). All should be carefully monitored by a qualified doctor.

The Feingold diet has received much attention in the treatment of hyperactive children. This diet is very strict. It removes additives, chewing gum, refined sugar, and many fruits and vegetables from the child's diet. Special cooking techniques are also necessary. The Fiengold diet has been successful in many instances, but the success rates have been difficult to reproduce in controlled studies. Much more research on the relationship between diet and hyperactivity is needed.

A conference, at least once a year, should be set up among the doctors, parents, and teachers to discuss and update therapy. The team approach, with the best professionals and patient parents, serves in the best interest of the hyperactive child.

CONCLUSION

The controversy and confusion about hyperactivity will probably continue for many years to come. This is probably because hyperactivity is a great masquerader. As noted, it can mimic or complicate conduct disorders, mental retardation, or drug and poison-related illness. Many physicians and psychologists cannot even agree as to

how to make a precise diagnosis and treat the disorder.

The new *Diagnostic and Statistical Manual of Mental Disorders*, third edition (DMS-III), offers some help to health professionals. It has introduced a new term "attention deficit disorder with or without hyperactivity." The DSM-III, therefore, focuses our attention on the child's ability to develop and learn, rather than purely on brain damage or physical activity. Needless to say, the DSM-III approach is not agreed upon universally, either. However, one should feel comfortable with the principles previously outlined: team participation, accurate diagnosis, careful use of diet or drug therapy, and plenty of patience.

TELEVISION VIOLENCE

Television, admittedly, is the most influential of all the mass communications media today. It seems all prevasive since over 98% of American homes have television sets. That totals more than 100 million television sets in our homes, including over 50 million color sets. Many households have two or more televisions.

In impoverished areas, the most treasured possessions of the family may be the television set. Indeed, it tends to be the window to the outside world, to excitement, adventure, riches, and far away exotic places. For many people, television vewing ranks third among all daily activities (after sleep and work) in terms of actual hours devoted to it. The television not only provides information, but shapes aspirations, vivifies fantasies, and molds values.

What Do the Children See?

It is estimated that television reaches at least three-quarters of all young people in America. With the set on an average of six hours per day, the typical American child may spend thirty (30) to forty (40) hours per week absorbing various programs. Numerous surveys by government and private concerns have documented some alarming trends in children's television viewing. These are examples:

- Half of all children's viewing time is actually spent watching so-called "adult programs."
- There is graphic violence in 70% of all prime time shows. More gunshots are fired in one evening of prime time television than in one year, in reality, in a medium-sized American city.
- By the time they are 18, most children will have spent much more time watching television than in school. During these years, the average child would have personally witnessed over 18,000 assualts, murders, rapes, and robberies on television.
- Casual sex on television is often sensationalized, socially acceptable, preverted, or downright crude. Commercials,

movies, soap operas, and game shows have all used sex to sell themselves to the public.

- Contrary to popular beliefs, many young children are late-night television viewers, watching shows even after midnight. Oftentimes, their parents are asleep, or out of the home.

The Evidence is Increasing

Since the 1950's, and tragic assassinations of the 1960's and 1970's (including Martin Luther King, Jr., President John F. Kennedy, and Malcolm X), the evidence continues to mount. Studies and examples continue to draw correlations between television violence and violent crimes. In 1969, Dr. Milton Eisenhower, then Chairman of the National Commission on the Causes and Preventions of Violence concluded:

> We believe that it is reasonable to conclude that a constant diet of violent behavior on television has an adverse effect on human character and attitudes. Violence on television encourages violent forms of behavior, and fosters moral and social values about violence in daily life which are unacceptable in a civilized society.

Since Dr. Eisenhower's statment, studies, examples, and hearing—too numerous to cite—have continued to draw correlations between television violence, family violence, street crimes, pranks, and tacit approval of the concept that "violence equals strength or masculinity." American viewing habits have not changed appreciably in ensuing years. Massive streams of violence are still pumped into our homes dialy. Also, juvenile crimes and pranks are on the increase. Commercial networks and pay cable networks enshroud violent acts in movies, cartoons, serials, news, and television specials. Major industries—such as automobiles, toys, and foods—continue to sponsor these programs. Many groups are concerned, and are battling the networks and sponsors. These include the American Medical Association, clergy, private associations and individual citizens. The problem is reaching epidemic proportions, and is influencing the values, attitudes and fears of all viewers, but especially the children. Children are increasingly expressing their fears about monsters, assaults, and even nuclear holocaust. Many fear that they have little hope for a meaningful future.

What Can Be Done?

The television set has become a tranquilizer, babysitter, parent, and primary educator to millions of children. It seems to be a conspiracy to capture their time and attention, and frustrates parents and teachers across the country. Yet, there are ways to tame the television set in your home, and to maximize the positive benefits therein. The following ten (10) suggestions are excellent starting points:

1. Turn the television *off* when necessary!
2. Encourage more family activities, such as worship, hobbies, homework, sports, parties, theater, and arts. Use local libraries, parks, and museums.
3. Read and talk with your children daily. Establish a story recital hour, and let everyone participate. Get their points of view, while developing good rapport and communication skills.
4. On a weekly basis, select a wholesome TV "diet," using television guides as the menus.
5. Always question the value of any given television program (moral, educational, emotional, entertainment, etc.). Let your conscience be your ultimate guide.
6. Watch the television programs with the children, and discuss them. Oftentimes, they will need your inerpretation of what is being viewed. Be creative in your discussion, or create games that sharpen critical viewing skills.
7. Use alternatives to commercial television, such as the Public Broadcasting System (PBS), radio, home videos, live dramas, books, and periodicals.
8. Try a television "blackout" for a week (or more). The obesrved effects on your family will probably surprise you.
9. Express your feelings by writing to local stations, networks, advertisers, and regulatory agencies. A few strong letters *can* make a difference.
10. Keep yourself informed via other parents, seminars, publications, Parent Teacher Associations, and local and national groups that monitor television programming.

Seek Out the Good

All television programs are not bad. There are many whole ome,

enlightening, and educational programs for every family member. Children, however, may not be able to discriminate the good from the not-so-good. Parents should, therefore, maintain active roles in the selection, the monitoring, and the interpretation of children's television viewing. If we seek out the good, we shall surely find it. Happy Viewing!

Part IV:
ENVIRONMENT

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KEEPING AHEAD OF LEAD POISONING

Lead poisoning means high levels of lead in the blood. These levels are crucial because the human body has no constructive use for lead. Lead simply causes illness. In 1924, Dr. J. C. Ruddock first reported that lead poisoning was common among children who ate lead-based paint chips found in their homes. He exclaimed that these children live in a "lead world." In the years that followed, many reports indicated the dangers to children in the inner city. However, not much was remedied nationally until the 1960's revealed many endangered children, due to lead poisoning. In 1971, the United States Congress passed the Lead Paint Poisoning Prevention Act, which stimulated local communities to screen high-risk children. These localities, in turn, sought to unite public and private agencies, community organizations, and concrened individuals to combat lead poisoning. Much work has been done, and the successes have been many. The battle, however, is not yet won. Our children still live in a "lead world" because lead seems to be everywhere—in the paint, dust, food and air.

SOURCES OF LEAD

Lead-based paint on many older homes and other buildings continues as a major source of leas. When paint peels on walls, baseboards, or windowsills, children can eat the chips. House dust and porch railings may also be quite hazardous. These homes are usually located in the older and poorer sections of the city. Lead poisoning, however, is not exclusively a disease of pooor people. It has been reported in most metropolitan areas, including the more affluent neighborhoods. Areas where old homes and buildings are being refurbished are at an increased risk, due to paint chips and dust. In addition, we are finding that not all lead poisoning results from paint chips or loose plaster.

Other sources include:

- Automobile exhaust

- Construction and renovation sites
- Industrial wastes
- Ink from newspapers, comic books, and magazines
- Improperly glazed cookware and pottery
- Some types of cans (especially evaporated milk cans)

As can be demonstrated, lead is all around us.

THE LEAD POISONED CHILD

A child's body does not dispose of lead easily. Lead tends to collect in the bones, soft tissues, and blood. A child may show signs of illness immediately, but most children show no signs for at least several months. A child suffering from lead poisoning may appear completely well. Be suspicious if your child develops any of the following:

- Behavior changes or temper tantrums
- Clumsiness
- Loss of energy
- Weight loss
- Hyperactivity
- Chewing on small objects and paper
- Vomiting spells
- Constipation or abdominal pain
- Seizures

WHO SHOULD BE CHECKED FOR LEAD POISONING?

Check children from one to six years of age who visit or live in areas whose lead is a hazard (old buildings, main highways, processing plants). The risk is increased from May through October, due to warmer weather and increased outdoor activity.

Younger children (up to 3 years of age) are especially vulnerable. They tend to be "explorers" who put small objects in their mouths while playing, or when hungry. Therefore, children at risk should be screened at least once a year with a simple blood test. These include:

- Children ages one to six years
- Children living in older dwellings

- Children who habitually put things in their mouths ("pica")
- Brothers and sisters of lead poisoned children
- Any child showing symptoms of lead poisoning

Some children will need to be checked more often than yearly. Even some pregnant mothers, and other adults who are at risk, should be screened by their private doctors or clinics.

TREATMENT

The treatment of severe lead poisoning usually involves hospitalization, painful injections, and a series of blood and urine tests. Oral medication may be needed after hospitalization. Milder causes may just require follow-up tests. In all cases, the homes and other places are checked by the local government, to locate and eliminate the sources of lead contamination.

COMMUNTIY INVOLVEMENT

Eradicating the lead poisoning problem requires a well-coordinated team effort. Because pollution causes lead poisoning, no one can handle the problem alone. Parents should check their homes, child care centers and children carefully. House dust, paint and plaster chips, and small toxic objects should be controlled. Children should have adequate diets, rich in iron, vitamins and minerals. Iron and zinc deficiencies complicate lead poisonings. All young children should have consistent medical care, including lead testing. If necessary, residents should have their buildings or nearby renovation sites checked by appropriate government agencies, and take legal action if needed. Government at all levels should continue the surveillance and needed enforcement actions. Lead poisoning can, and should, be prevented.

Our children's saftey involves us all. Each of us has an important role to play in insuring their happy, healthy future.

Part V:
CONCLUSION

A PERSONAL NOTE

Literally millions of children can, and should, benefit from the establishment of preventive health practices. Many former major killers and cripplers of children, such as infectious diseases, are rapidly being eradicated. Great technological and communications systems are upgrading the standards of care for ill and injured youngsters across the nation. New techniques, medications, and approaches reach public attention daily, as more and better research is completed. Huge hospital-industrial-insurance-personnel conglomerates are emerging to replace the neighborhood doctor who makes house-calls. Yet the outcry is the same among consumers, wherever I discuss health care for children. "Doctors are too *expensive*!" "How do I know when I am getting good medical care?" "Why is the system so *complicated*?" "Are these new medicines really safe?" "Why won't anyone let me know what is *really* happening with my child?"

The public is crying out for sound advice and practical information to manage their own health affairs comfortably and competently. The request is quite reasonable. Acceptable responses from the medical community at-large, however, are far too slow in coming. As the needs of children are changing, so are the consumers of child health care services. More emphasis is now being placed on growth, development, safety, learning, behavior, chronic illnesses, and children with special needs. Families, are increasingly questioning the value of the care they pay to receive. They, in turn, seek information that enables them to accept more responsibility for their health. The newer stress of modern urban life requires greater self-sufficiency and coping skills. The health care system has too often been viewed as promoting dependency for financial gain. *No one* should have a monopoly on health care, and *no one* monopolize health information! The public is ready, willing, and able to receive it. A few pioneers have stepped foward to deliver via conversation, formal seminars, the print and electronic media. More pioneers are needed.

This short, but significant volume, *Your Child and Good Health: Six Topics in Urban Preventive Child Health*, is but one in a series of efforts by this author to inform and advise those who care for

children. The time has come to share our knowledge, skills, and strengths on their behalf. Hopefully, these few words will not fall upon deaf ears, unseeing eyes, unthinking minds, or unfeeling hearts. The future belongs to the children only if we prepare them for it. The next step is *yours*!